Health Care
Financing Administration

# Forum

September/October 1977

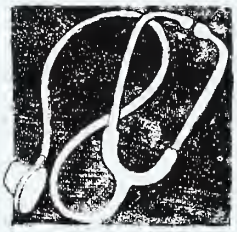
## Team Effort Pays Off in Curbing Fraud and Abuse.

## HMOs Stimulate Competition

## Pinpointing the Costs of Hospital Services.

# Children should be seen.

# And heard.



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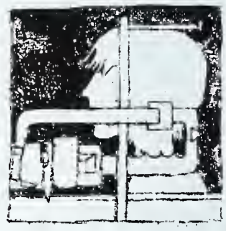

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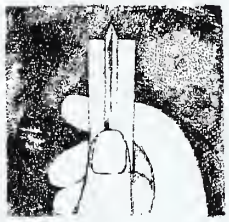

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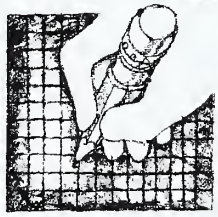

# And treated.

Preventive health services are important to vulnerable children . . . especially those from poor families, who have 3 times as much heart disease, 7 times the visual impairment, 6 times the hearing defects, and 5 times the mental illnesses. That's why there is an EPSDT program . . . Early and Periodic Screening, Diagnosis, & Treatment. Children in Medicaid families qualify for EPSDT.

# Forum

Volume 1 Number 1 • Sept./Oct. 1977

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## A new magazine

The *Forum* is the magazine of the Health Care Financing Administration. The *Record,* which was the SRS magazine and continued to be published during the HEW reorganization, ceased publication with the June/July issue. News of the programs administered by SRS will be provided by the agencies now responsible for those programs.

The new magazine will not simply record events, but will strive to bring health care issues into sharper focus and to encourage new approaches for resolving these issues. To accomplish this, the *Forum* will present as wide a range of viewpoints as possible.

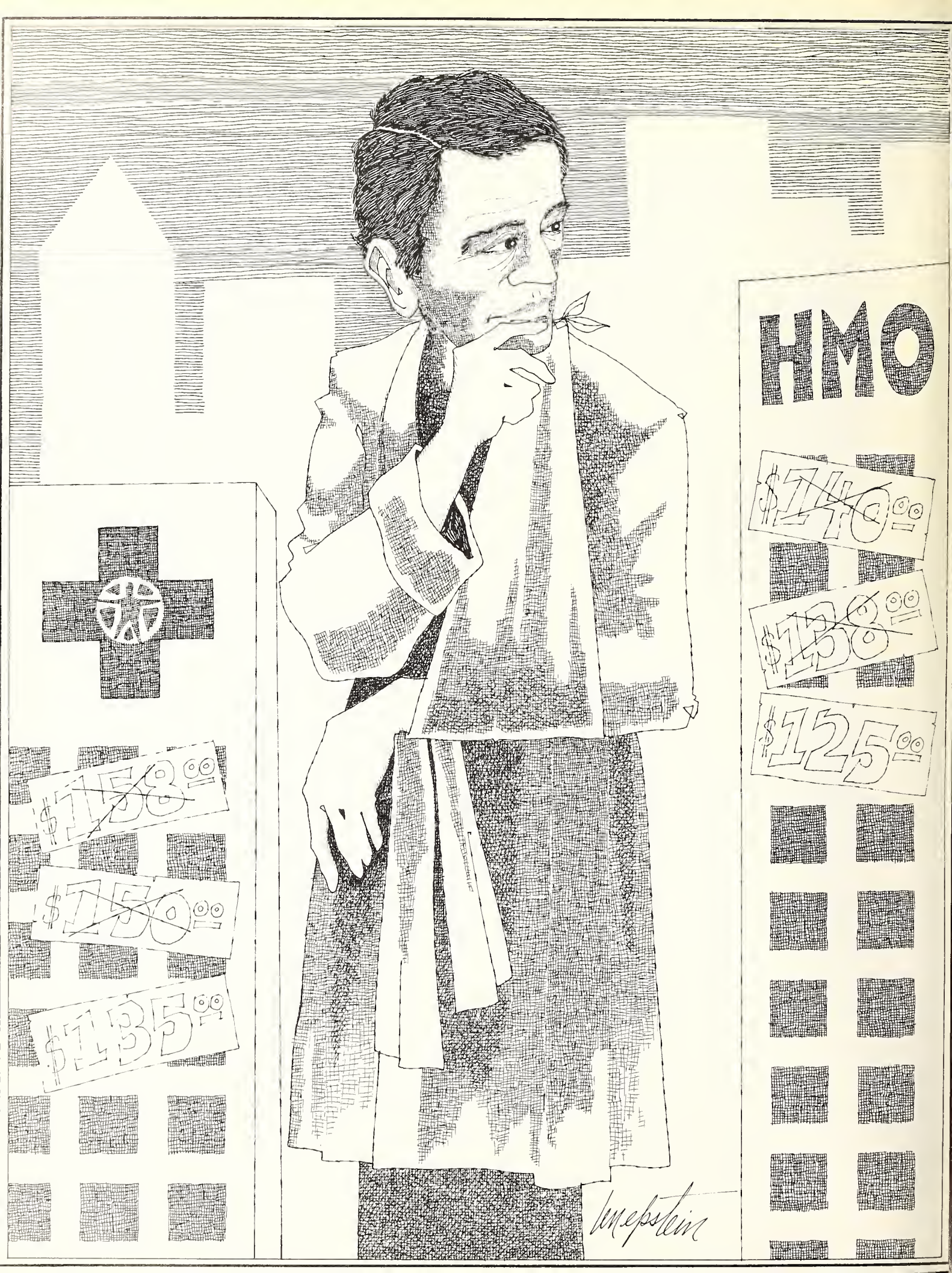
While the primary responsibility of HCFA is to efficiently manage the Medicare and Medicaid programs, nearly every activity in the health field affects these programs. Therefore, the magazine will address subjects as wide ranging as the views we hope to solicit.

One thing will not change, however. The same high regard for journalistic standards that won the *Record* an Award of Excellence from the Society for Technical Communication and an international award from the Society will continue.

The magazine will be published six times a year. Subscriptions to the *Record* will be automatically converted and extended, so that each subscriber will receive the correct number of issues.

We welcome your ideas on subjects the magazine should address and invite you to submit articles for publication.

Martin Judge


HMO
$150.00
$135.00

# HMOs Stimulate Competition; Bring Hospitalization Rates Down.

by Martin Judge, Editor

The rate of hospitalization goes down in a community when a health maintenance organization comes to town and captures a significant part of the market. So says a report by the Federal Trade Commission* which has analyzed competition between these organizations (called HMOs) and Blue Cross. The report also says there are indications that, when an HMO is established, Blue Cross expands its range of services.

Those who advise going slowly with the HMO concept hear this from HEW Under Secretary Hale Champion: "How much more proof does one need than the studies that show HMOs' ability to provide care for at five to 35 percent less than the fee-for-service sector? What is there left to demonstrate when over 25 HMO-type organizations have been providing good quality care to four million enrollees for the last 10 years, and Kaiser and others have been going strong for over 30 years?"

HMOs have been operating since 1929, but their growth was slow until the 1970s. Since then enrollment has increased to more than six million persons.

One reason HMOs did not expand more rapidly is that until very recently their premiums were higher than conventional health insurance premiums. Many consumers balked at this higher cost and did not look further to find the more extensive benefits offered by the HMO.

However, several recent developments have made the prospects for HMOs extremely bright. "Today, the costs of coverage under an HMO and a conventional health insurance policy are highly competitive — a dollar or two one way or the other in some cases," says Dr. Frank Seubold, director of the Division of Health Maintenance Organizations. In addition, HMOs offer about one-third more services per dollar than conventional programs.

This is because HMOs have been able to limit their cost increases, while Blue Cross and the 1,000-odd private health insurance carriers have not, according to the FTC report. Last year, Blue Cross and Blue Shield increased their premiums about 35 percent in some areas, while the average qualified HMO (an HMO which meets Federal standards) held its premium increase to 19 percent.

A major reason for this enviable performance is that HMOs are as cost-conscious as any business, while hospitals have little or no incentive to hold down costs. Hospitals simply pass increased costs along to the health insurance companies or Blue Cross and Blue Shield. On the other hand, HMOs have been able to control costs by treating enrollees on an outpatient basis whenever possible.

A recent study shows HMOs paid for an average of 406 days of hospitalization per 1,000 persons**, compared with 760 days in the hospitals per 1,000 persons covered by all other types of insurance plans.

Another major factor in containing costs, according to the FTC report, is that HMO physicians generally are salaried or are paid in accordance with the patient population they

## Types of HMOs

HMOs come in three varieties: (1) the staff model; (2) the individual practice association; and (3) the group practice.

- A staff HMO provides services through physicians who receive salaries from the HMO. In some cases physicians may receive incentive payments in addition to salary. Services are provided in a clinic setting with the number of service outlets depending on the number of enrollees and their area of disbursement.
- The individual practice association is usually sponsored by the State or county medical association. Enrollees pay monthly premiums to the HMO, which contracts with physicians to provide services on a fee-for-service basis.
- A group practice is an HMO which contracts with a medical group, partnership or corporation composed of health professionals to provide health services. All physicians are usually located in one facility and are paid a salary or on the basis of the number of persons for whom they are responsible.

*_The Health Maintenance Organization and Its Effects on Competition_, a staff report of the Bureau of Economics published July 1977, prepared by Laurence G. Goldberg and Warren Greenberg.

**Crude rate.

serve, rather than for each service they provide. This reduces the incentive for physicians to order unnecessary hospitalization for patients or to see patients more often than necessary.

### Promoting competition

Frequently, news that an HMO will be established in a community causes organizations such as medical societies and Blue Cross to set up their own HMOs or increase benefits and concentrate on more effective cost controls. However, the FTC report said there was no pronounced price cutting in any of the nine areas† studied.

The arrival of an HMO in an area often seems to be followed by the formation of individual practice associations or IPAs — HMOs set up by physicians themselves. The principal objective of such an association is to maintain the traditional payment system — a fee for each service performed for the patient. The study shows IPAs were preceded by HMOs in 11 of 13 States covered by

†The areas, Minneapolis-St. Paul; Chicago; Rochester, New York; New York City; Washington; Northern California; Southern California; Portland and Hawaii, were chosen because they contain nearly half of all HMOs and more than three-fourths of all HMO enrollees.

## Comparing Hospital Use by HMO and Blue Cross Members

| | Average length of stay (Days) | | Number of inpatient days per 1,000 members (Annualized) | |
|---|---|---|---|---|
| | Qualified HMOs | Blue Cross | Qualified HMOs | Blue Cross |
| New Haven, Connecticut<br>Community Health Care Center Plan | 6.00 | 6.72 | 443 | 739 |
| Providence, Rhode Island<br>Rhode Island Group Health Assoc. | 4.88 | 7.10 | 368 | 695 |
| Rochester, New York<br>Genesee Valley Group Health Assoc. | 5.28 | 6.66 | 242 | 673 |
| Pittsburgh, Pennsylvania<br>Penn Group Health Plan | 6.41 | 6.88 | 520 | 929 |
| Greenville, South Carolina<br>Piedmont Health Care | 4.75 | 5.70 | 512 | 740 |
| Daytona Beach, Florida<br>Florida Health Care Plan | 5.90 | 5.81 | 325 | 789 |
| Evanston, Illinois<br>North Communities Health Plan | 6.42 | 7.82 | 485 | 972 |
| Grand Junction, Colorado<br>Rocky Mountain HMO | 4.64 | 5.74 | 566 | 786 |
| Tacoma, Washington<br>Sound Health Association | 3.51 | 4.47 | 406 | 553 |

Note: Data are not adjusted for age, sex or other characteristics affecting rate of use. Data reported by HMOs exclude newborn and psychiatric inpatient days. Data reported by Blue Cross are for its total regular membership for the year 1975, excluding complementary coverage to Medicare members.

the study, and in 10 of 17 metropolitan areas.†† However, this data alone was not sufficient to conclude HMOs caused the formation of IPAs.

IPAs generally attempt to institute cost controls while preserving the patient's free choice of physicians. The study finds evidence that these associations can control costs, but the data was insufficient to make a conclusive statement.

The Blue Cross response varied. In the five eastern areas surveyed, Blue Cross made little or no response to the establishment of HMOs. However, in the four western areas, Blue Cross raised or altered benefit packages to compete with Kaiser HMOs. The study shows that Blue Cross is "involved" in from 27 to 49 HMOs — depending on how involvement is defined and has already invested more than $55 million of its own money in HMOs.

Holding other factors constant, the greater the market penetration of HMOs, the lower the hospitalization rate of both government and non-government enrollees of Blue Cross, and the shorter the term of hospitalization for government-enrolled maternity patients. (There was insufficient data for a comparison of non-government maternity enrollees.)

Reaction to HMOs by private insurance companies appears to have been slight. None of these companies had more than five percent of the market in any geographic area, and none felt they were affected by HMOs. However, according to a separate survey 54 insurance companies are involved in operating HMOs or in HMO development.

### Reaction to HMOs

Many physicians oppose HMOs on the grounds they destroy the traditional personal relationship between patient and physician. They say a patient cannot be sure of seeing the same physician on each visit and continuity of care is lost. Others counter this argument by pointing out that patient histories assure such continuity. Some HMO enrollees report long waits for services; others find no significant difference between an HMO and conventional health care delivery.

At R. J. Reynolds Industries, 15,000 of 50,000 employees chose to enroll in an HMO when the opportunity was offered in May of 1976. Today, 19,000 employees are on the waiting list to enroll, and for the past 12 months the list has been growing at the rate of 500 persons a month.

### Forming an HMO

Establishing an HMO has become progressively easier since the Health Maintenance Organization Act of 1973 authorized HEW grants and loans to assist in forming them.

Public and nonprofit organizations are eligible for three types of grants. HEW can grant up to $75,000 to study the feasibility of establishing an HMO, $200,000 for developing the planning phase and up to $1 million for an initial development grant to put the HMO into operation. The initial development phase covers such activities as recruitment of personnel, an enrollment campaign, purchase of equipment and development of quality assurance procedures.

The HMO Act supersedes several aspects of State laws which previously inhibited the development of HMOs, including:

- The necessity for medical societies to approve the organization and operation of an HMO.
- Participation in the delivery of services by all or a certain percentage of physicians in the HMO's service area.
- The need for physicians to be represented on policy and decision-making bodies.
- Requirements that the HMO meet the same standards for initial capitalization and financial reserves as other insurers of health care services doing business in the State.

While there are many HMOs, not all are qualified by HEW. Those which meet the standards for qualification are eligible for loans or loan guarantees. Public and non-profit organizations can receive loans of up to $2.5 million over the initial five-year period (not to exceed $1 million in any fiscal year). The loan is to be repaid within 20 years.

Profit-making organizations are eligible for loan guarantees to complete their planning and initial development, and to meet the requirements necessary to be qualified by the Federal Government. Loan guarantees are for up to $1 million for any fiscal year and may not exceed $2.5 million for the initial five-year period.

Qualified HMOs are also aided in expanding their membership by a law which requires a company to provide its employees with the option of joining an HMO if at least 25 employees live within its service area.

To receive Federal qualification, an HMO must provide the following basic services:

- Physician services.
- Outpatient services and inpatient hospital services.
- Medically necessary emergency health services.
- Short-term mental health services.
- Medical treatment and referral services for abuse of or addiction to alcohol and drugs.
- Diagnostic laboratory and diagnostic and therapeutic radiologic services.
- Home health services.
- Preventive health services.

Since the HMO Act four years ago, 261 grants totaling more than $55 million have been awarded to 168 organizations. Forty have been qualified and another 50 have applied for qualification. Currently, membership in qualified HMOs is increasing at about 12 percent per quarter.

The future looks bright for HMOs. Consumer, congressional and industry response suggests that HMOs are meeting community health needs. In addition, President Carter said recently that he was "committed to strengthening competition in the health industry. For example," he said, "we should encourage HMOs and other organizational arrangements which give providers an incentive to reduce costs, and we should encourage consumers to become more aware of the charges of different providers." ■

†† *Standard metropolitan statistical areas.*

# Putting the Squeeze on Rising Hospital Costs.

"...a hospital is reimbursed on the basis of cost or whatever fee it elects to charge. This reimbursement system fails to give hospitals any economic incentives to hold down costs."

*To combat the runaway cost of hospital care, the Administration has proposed measures to substantially limit the increase in hospital charges — nine percent for the first year. For details on how costs would be contained, the Editor talked to Health Economist Karen Davis who is Deputy Assistant Secretary for Planning and Evaluation for Health.*

**QUESTION:** Why has the cost of operating a hospital gotten out of hand?

**DR. DAVIS:** Two factors that are unique to the hospital industry have produced this explosive growth in costs. First, more than 90 percent of all hospital costs are paid for by someone other than the patient — Medicare, Medicaid, Blue Cross, or other insurance carriers or public programs. Few patients even know what their hospital stay costs. This indifference on the part of the patient and sometimes the doctor encourages unnecessary hospital use. Also patients have limited freedom to shop around among hospitals on the basis of cost or any other factor. Usually the doctor tells the patient which hospital to go to.

The second cost-escalating factor is that a hospital is reimbursed on the basis of cost or whatever fee it elects to charge. This reimbursement system fails to give hospitals any economic incentives to hold down costs.

Indeed, it encourages them to add expensive new facilities and equipment. Since the cost of exotic equipment, such as computerized diagnostic x-ray and open-heart surgery units, can be apportioned among all patients, hospitals tend to buy such equipment. For this same reason hospitals tend to expand their physical plants. The reimbursement system has created this "spend more, get more" atmosphere in which inefficiency results, not in penalties, but in monetary reward.

**QUESTION:** Is this sophisticated equipment really necessary — is it cost effective?

**DR. DAVIS:** Improved equipment and new technologies are largely responsible for the fact that Americans now spend far fewer days per hospitalization than they once did. Of course that's good, but it also contributes to the problem of unused hospital beds. We have spent the money to supply sufficient beds for our previous technology. Now we spend more money for new technology which reduces the need for the number of beds we created.

The question is not whether communities should have the best possible health facilities, but whether every hospital should purchase expensive, exotic equipment. Underused accoutrements and empty beds keep pushing costs upward.

Since hospitals account for 40 percent of all health care spending, their escalating costs exert enormous inflationary pressure on the national bill for health care. We are convinced that costs can be reduced without reducing the quality of patient care.

**QUESTION:** Can you put some hard numbers on the inflationary pressure?

**DR. DAVIS:** In the past fiscal year alone, the nation's total expenditure on health care climbed 14 percent to reach $139.3 billion, or 8.6 percent of the gross national product. In 1966, health care costs totaled just $42.1 billion, or 5.8 percent of the GNP. If this trend continues — and it will unless something is done soon to halt it — health care costs will double every five years. During the past decades Federal outlays for health care have increased more than six-fold.

Ironically, we as a nation have been investing so much in curing illness by the most expensive means — that is, acute-care hospitalization — that we have not been able to afford the steps to help us avoid acute illness. There are many serious health problems in this country affecting the aged, children, rural citizens and the working poor. Attention to primary and preventative care, particularly for children, has suffered. We must redirect the resources now spent on costly and unnecessary hospital care to provide remedies for those pressing health needs.

**QUESTION:** Exactly what can be done to halt runaway hospital costs?

**DR. DAVIS:** We all realize they can't be stopped overnight, but a concerted effort by hospitals, the medical profession, insurers, government administrators, and community

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leaders — and even patients themselves — can accomplish a lot. Last April the Administration proposed a package of hospital cost containment measures, and this legislation is now before the Congress.

**QUESTION:** How would the proposed legislation eliminate the problem?

**DR. DAVIS:** A cap would be imposed on increases in charges to inpatients. The program is targeted to begin in October 1977 and the increase in costs for the first 12 months would be limited to nine percent.

**QUESTION:** Why was the limit set at nine percent?

**DR. DAVIS:** The basic limit on increases in total inpatient revenues is set by a formula reflecting general price trends in the economy as a whole, plus an additional amount to accommodate an increase in the volume of services. The formula would use the rate of increase in the Commerce Department's "GNP deflator," which measures price changes in the whole economy.

To determine the limit, we would take the average annual increase in hospital costs for the preceding two calendar years and the increase in the GNP deflator for that same period. We would multiply the difference between the two by one-third and add to that the increase in the GNP deflator for the most recent 12-month period ending on June 30. That sounds more complicated than it is — let me give you an example:

Assume that for 1975 and 1976, the increase in hospital costs was 15 percent and the increase in the GNP deflator was 6 percent. Also assume that the increase in the GNP deflator for the 12-month period ending on June 30 of this year was six percent. Under our formula, that would be:

$$6\% + \frac{(15\%-6\%)}{3} = 9\% \text{ increase.}$$

**QUESTION:** Would hospitals be told exactly how and where they must cut costs?

**DR. DAVIS:** No, this is a flexible measure that leaves institutions great freedom to identify the economies appropriate for their local situations. Also, the limitation would be modified if a hospital experienced an exceptional change in patient load, markedly increased its capacity or types of services, or underwent major renovation or replacement of its facility. And there would be an adjustment for increases in pay to employees, other than supervisory staff.

**QUESTION:** What are some of the cost-cutting steps hospitals might take?

**DR. DAVIS:** Many can cut down on unnecessary hospitalizations. As many as 100,000 of the 700,000 persons in our acute-care hospitals — or 15 percent — do not need to be there and could be better cared for at home, in skilled nursing facilities or on an outpatient basis. Such patients

"As many as 100,000 of the 700,000 persons in our acute-care hospitals —or 15 percent—do not need to be there and could be better cared for at home, in skilled nursing facilities or on an outpatient basis."

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are generating unnecessary charges of $2.6 billion per year.

Parenthetically, I should note that the hospital cost containment legislation would ban any increase in hospital beds in areas having a surplus of beds, and there would be a dollar limit on new capital expenditures by hospitals.

There are many other ways for hospitals to control costs: conserve energy in heating and cooling, cut back on unneeded tests and therapies ordered for patients, eliminate Friday and Saturday admissions — non-emergency of course — if laboratory and operating facilities are closed weekends.

**QUESTION:** Speaking of unneeded tests, do you feel the threat of malpractice suits contributes to rising costs because physicians tend to overkill in ordering X-rays, laboratory work and the like to protect themselves?

**DR. DAVIS:** Certainly this has been long suspected, although it is hard to prove and I know of no direct evidence that it is occurring. I do feel, however, that fear of malpractice suits can easily contribute to excessive use of hospital tests.

**QUESTION:** Have standards of performance been developed for the various departments of hospitals to help determine if they are operating efficiently?

**DR. DAVIS:** No, there are no formal standards at this time. At present there is insufficient data on the classifications of hospital departments and services. Of course, if a hospital files for an exception to the percentage increase limitation on the grounds of, say, a change in the complexity of the cases it handles, we would examine its records, including those of the different departments to be sure it was being run efficiently. There are certain criteria that can be used to assess the general performance of hospital departments, but it is not a packaged program. Without an in-depth investigation, we could spot only markedly poor performances.

**QUESTION:** If a hospital says it can't meet the proposed nine percent limit on annual cost increases, can it be fined or made to stop its building program?

**DR. DAVIS:** Hospitals could be required to pay a tax equal to 150 percent of the amount overcharged. But these sanctions would be applied only as a last resort. We hope that excess revenues can be dealt with in a reasonable manner by all parties.

One built-in penalty is that Medicare, Medicaid and Blue Cross will simply not pay charges that exceed the specified percentage for that year. If private insurers or individuals who pay their own hospital bills are charged more than the allowable amount, the hospital would be required to adjust its fees the following year to compensate for overcharging.

As for excessive expansion, there is already in place the "certificate of need" program, whereby each State

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reviews major capital expenditures for hospital equipment and buildings of over $100,000. A hospital must apply for a certificate of need from the State agency designated by the Health Planning Act of 1974. The cost containment bill uses the same system and provides a budget of $2.5 billion per year for acute-care hospital capital improvements, subject to certificate-of-need approval. Without such approval, the hospital cannot obtain reimbursement from Medicare and Medicaid for those expenses.

**QUESTION:** What is the projected time table for the hospital cost-containment program?

**DR. DAVIS:** That depends upon congressional action, but if Congress does approve the proposal, HCFA is prepared to put it into effect next January 1. The system can be implemented quickly and simply. It requires no new data collection or reporting forms and can be readily understood by hospitals.

This is intended to be a transitional program that will precede a more fundamental reform of the ways in which hospitals are paid and health care services are distributed. The bill provides that the Secretary of HEW submit recommendations for a longer-range program next year.

**QUESTION:** Some say that national health insurance will never be possible unless we can hold down hospital costs. Is this true?

**DR. DAVIS:** Failure to contain inflation in health care costs could add significantly to the cost of national health insurance.

The added cost to the nation of national health insurance was estimated in 1975 to range from $10 billion to $25 billion a year. With another five years of current inflationary rates, the price-tag would be in the range of $20 billion to $50 billion.

**QUESTION:** You mentioned earlier that the nation now spends 8.6 percent of its gross national product on health care. Does the Administration have a goal of ultimately lowering that percentage to, say five percent?

**DR. DAVIS:** Not at this time. Our most urgent job is controlling the rate of inflation in health care. It is shocking to realize that hospital costs have gone up more than two-and-one-half times faster than the consumer price index for all goods and services over the past 25 years. As we bring that under control, we will begin to tackle the problems of cost effectiveness.

**QUESTION:** The idea of controlling runaway health care costs while maintaining a high standard of care is most appealing, but is it possible to do both at the same time?

**DR. DAVIS:** In health care, "more" is not necessarily "better." Hospitals can reduce costs in various areas so as to actually increase the quality of care and put the hospital industry in better shape to serve our patients and the whole health care system. That's our goal, and we will be working diligently to achieve it. ■

# Are you sure you know what family planning is <u>all</u> about?

If you think family planning means taking measures to prevent unwanted pregnancies . . . you're only partially right. Certainly, family planning does offer ways to have children only when you want them . . . can afford them the best . . . and love them the most.

But did you know that it also means:

- making sure you're healthy before, during, and after pregnancy
- counseling and helping solve fertility problems for couples who want to have children but can't
- counseling men on male responsibility for birth control
- counseling young people about their problems and how having a baby can affect their health and their lives

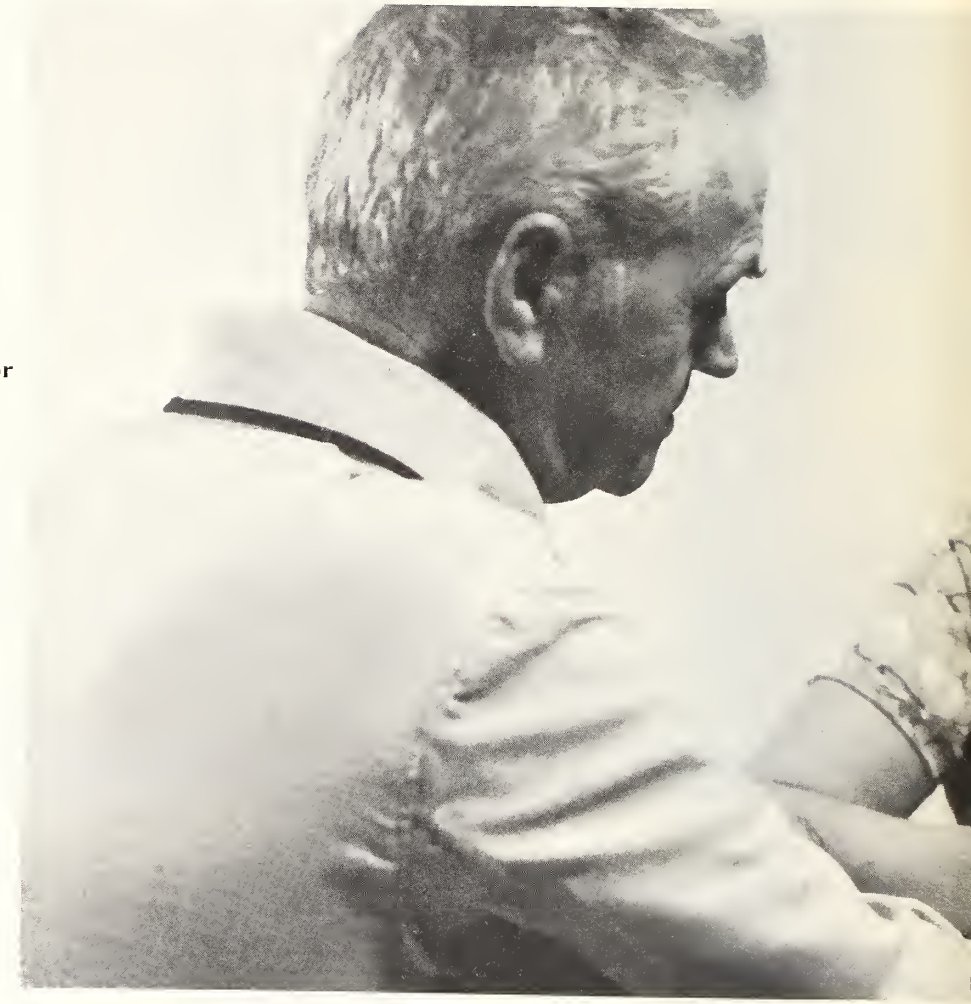
So be sure you know ALL about family planning . . . <u>it means more than you may have thought.</u>

All these services are available from the family planning clinic in your community, your local health department, or your own physician.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

# Medicare Expands Information Services to Beneficiaries.

by Virginia Douglas, Assistant Editor



Ordinarily, Sam Smith was pretty healthy, even if he was 73 years old. But his ulcer had flared up and the doctor had told him he would have to go into the hospital for treatment. Luckily, he hadn't needed surgery. After a few days in the hospital, he was feeling much more chipper and ready to get back to his garage woodworking equipment.

One thing bothered him though. This was the first big expense he'd had for health care since he became eligible for Medicare. Like most people, he hadn't paid much attention to how Medicare worked when he didn't need it. Now that he did, he wondered how much of the hospital bill it would pay, if it would cover his doctor bills and what he would have to do to get things started?

Help with these questions came unexpectedly when his bedside telephone rang. A pleasant voice asked if he had any questions about Medicare or needed help in understanding the Medicare benefits he would be entitled to. Yes, he did and he did feel well enough to talk with her. Mrs. Arnold, a brisk yet friendly woman, seemed to know exactly how to handle the whole business and in a short time, Sam felt he understood the workings of the system almost as well as his lathe.

Sam was one of the first recipients of an expanded beneficiary assistance program sponsored by the Medicare Bureau. Now well underway in several States in New England on a pilot basis, plans are being made to provide this service throughout the country as arrangements are made with volunteers and organizations willing to help.

**Hospital program**

In New Hampshire and Vermont, some 25 elderly volunteers are working at seven hospitals and a skilled nursing home handling a total of about 150 patient inquiries about Medicare weekly. The New Hampshire/Vermont volunteers provide general information for beneficiaries, help to clarify Medicare rules and assist in filling out the necessary forms. But the volunteers offer something more — consolation and friendship, which help to relieve the stress of an elderly person like Sam.

Who are the volunteers? Mainly retirees with professional backgrounds or those accustomed to working with people. They were recruited by the Medicare intermediary, the New Hampshire/Vermont Health Service, from various senior citizen organizations, such as senior councils and local chapters of the American Association of Retired Persons. After receiving 20 hours' training, the volunteers work without supervision, even scheduling their own hours.

"They aren't supposed to be instant experts on Medicare," says Donald Wilson, Medicare Program Officer for the New England projects, "But that is what they are in effect because they are only a telephone call away from staff experts."

The cost of the program is low. The hospitals provide working space for the volunteers and the intermediaries pay the telephone bills. The telephones bypass hospital switchboards to avoid overloading them and to simplify billing.

One goal of the program is to ease the inquiry load on social security offices (there are 75 in New England), Blue Cross and other intermediaries, and hospital admissions' staffs. The


volunteers keep records of each visit with a beneficiary, including the nature of the visit and the final disposition of the problem.

The Medicare Bureau and the New Hampshire/Vermont Health Service plan to evaluate the cost-effectiveness of the volunteer program. However, the Medicare Bureau points out that cost savings are not the primary concern. "Our goal is to help the beneficiary — and that might even cost more," says Mr. Wilson. Associations for the elderly in the State are pleased with the program and feel that it is of significant value, even though thus far limited in scope.

This fall, the program is being expanded to place volunteers in all 38 acute-care hospitals in the two States. Eventually, plans call for counseling Medicare beneficiaries who are not hospitalized.

**Community program**

Connecticut is also using volunteers to assist Medicare beneficiaries. Some 100 persons are stationed at town halls, offices of the Visiting Nurse Association and other key locations. Their assignment: to assist Medicare beneficiaries in completing forms, explain the assignment agreement, and provide information on coverage and other matters. They do not go to hospitals, but occasionally call on beneficiaries in their homes or in nursing homes. Volunteers are trained by personnel from the Medicare carrier, the State Medicaid office and the Connecticut Medical Service, the major supplemental medical insurance plan in the State.

**Nationwide effort**

The volunteer activities in New England are part of a nationwide effort by the Medicare Bureau to be more responsive to the needs of beneficiaries. Last year, the bureau set up the Office of Beneficiary Relations, which is undertaking a variety of activities to inform and assist Medicare beneficiaries with the help of national groups of elderly people.

Various kinds of services are being tested, advisory groups are now being set up in Maine and Massachusetts, and consumer opinion is being sought about the effectiveness of the Medicare program and suggestions for program improvement. Consumers will be asked to review Medicare brochures and forms and suggest ways to increase their clarity. For example, one beneficiary advisory group helped redesign Medicare's Request for Payment. The group felt the form lacked sufficient space to answer some of the questions. It will be field tested for verification.

In Maine, the Cumberland-York Senior Citizens Council recommended simplification of language in a notice going out to more than 140,000 Medicare beneficiaries. The problem: technical terms with which only the Medicare staff was familiar.

Elsewhere in the country, the National Council of Senior Citizens is joining with the Medicare Bureau to sponsor six projects — in Boston, Memphis, Denver, Newark, Baltimore and Monterey, California — using elderly persons to assist Medicare beneficiaries. The program, to be administered by the NCSC, will begin with hospital patients and may expand to include visiting beneficiaries in their homes. Techniques that prove successful in New England will be used in the program. Medicare regional offices will assist with training.

"This is an exciting new dimension in further improving Medicare's beneficiary assistance efforts," says Albert Fox, who heads the Medicare Bureau's Office of Beneficiary Relations. "We are bringing volunteers and beneficiary-oriented organizations into a working partnership with the Medicare program. The response has been enthusiastic and demonstrates what we sometimes forget — that people are eager to help each other if we only give them the opportunity." ■

# Team Effort Pays Off in Curbing Fraud and Abuse.

by Herman Spector

Although the merger of the investigative arms of Medicare and Medicaid is just six months old, indications are that the new combination is paying off in controlling fraud and abuse.

"One of our greatest accomplishments is that we have been able to create an awareness within the ranks of those providing health care services that there is a vigorous organization examining the quality of services they render, together with their methods of billing and of receiving payment," says Donald Nicholson, acting director of HCFA's Office of Program Integrity. "This has been accomplished with the help of Federal and State prosecutors, the Inspector General's Office, the Secret Service, the FBI, the Postal Inspection Service, State agencies, contractors and local groups of physicians who review the work of other physicians."

For the first time the combined efforts of reviewers, investigators, and law enforcement agencies at the Federal, State and local level now constitute a common force to battle fraud and abuse.

This solid front is vital. For instance, in a number of cases, convictions of Medicaid and Medicare fraud was won on mail fraud indictments rather than under the general criminal code. In these cases postal inspectors were extremely helpful in working with State and Federal investigators to compile the necessary evidence.

In other cases, before HEW had full jurisdiction over the investigation of forged checks, the Secret Service would make these investigations.

In addition, State and local prosecutors and law enforcement agencies have helped hasten investigations by cutting the red tape that often confronts investigators crossing lines of jurisdiction.

One solid indication that health care providers are aware of this more intensive enforcement is the way their billing procedures have changed. In the past, bills were deliberately vague about the type of services performed because many screening devices could not detect some types of irregularities. A podiatrist, for example, would submit a bill for "foot care" and it would be paid without question. Today, such a bill would not be validated for payment. It would have

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*Herman Spector, an attorney, heads the information section of HCFA's Office of Program Integrity. He has been a member of Medicare's program integrity staff since 1969.*

to be specific, such as "removing two ingrown toenails requiring surgery."

"The word is getting around that the Government won't pay just any claim submitted," says Mr. Nicholson.

Committees of local physicians who review the work of other physicians have also helped spread the word. In many cases in the past, when practices of physicians were questioned and they were brought before the committees, superficial reviews would report no improprieties. Today, more cases are being presented to the committees, which are taking action in a greater percentage of cases. The fact that questionable practices are identified constitutes a strong deterrent to the continuation of such practices by the same physicians.

**Stronger legislation**

Help also appears to be on the way in the form of legislation. Congress is currently considering a bill (H.R. 3) designed to strengthen the Government's ability to detect fraudulent activities and to expedite prosecution. The bill will:

- Provide 90 percent Federal matching funds to support the antifraud activities of the States.
- Make fraud violations in Medicare and Medicaid a felony rather than a misdemeanor.
- Require any practitioner convicted of a criminal offense against either Medicare or Medicaid to be suspended from both programs.
- Allow Federal investigators access to providers' records. ,
- Require disclosure of providers' business relationships with owners, officers or directors of corporations having an interest in a health care facility and disclosure of the providers' ownership of such facilities.

The bill is expected to become law soon. In preparing for its implementation, the Program Integrity staff is designing forms that can be used by both Medicare and Medicaid. Standardizing forms and instituting other types of uniformity in the two programs is expected to result in considerable savings in operating costs, while yielding a higher rate of productivity generally.

**Joining forces**

An Office of Inspector General of HEW was created a year ago to establish policies and promote economy and efficiency in all HEW operations. The office has a separate antifraud staff (known as the Office of Investigations) which has been working in concert with HCFA's network of investigators.

The support of State prosecutors is essential for controlling fraud and abuse, so a new approach is being developed to facilitate exchange of data between the Federal Government and the States. This should expedite prosecution and eliminate much duplication, saving millions of dollars. Information acquired by the Program Integrity staff will be the basis for tracking trends on a local and national scale, and for comparing State activities. The exchange of information conforms with the rigid controls imposed by various laws governing confidentiality.

Thus far investigations have resulted in nearly 400 convictions on Medicaid fraud. Some 350 cases are currently under consideration for prosecution, while both State and Federal agencies continue to monitor bills, investigate complaints and make on-site inspections of health care facilities.

Since hospital and nursing home care accounts for almost 70 percent of Federal health care expenditures, an important part of the effort to control fraud and abuse is the work of committees of physicians (Professional Standards Review Organizations) who review the care prescribed by their fellow physicians. Between June 1974 and June 1976, the number of hospitals in areas served by PSROs increased from 643 to 2,752. It is projected that, by October 1978, PSROs will cover a majority of the 7,000-plus hospitals in the country. Recently, PSROs expanded operations to review skilled nursing facilities and intermediate-care facilities.

PSRO reviews are a valuable source of leads about improprieties, such as harmful or inferior services, unnecessary hospitalization and, in some cases, abuse and fraudulent activities.

The increased activity of PSROs and HCFA efforts to seek out fraud and abuse is expected to motivate the public to more readily report questionable practices that come to their attention. This increased activity should also deter potential violators.

**Ferreting out fraud**

A key technique used to spot fraud and abuse is a computer screening which quickly identifies those physicians and pharmacists who are most likely providing excessive services and drugs to Medicaid patients. The records of these providers are then analyzed to determine those cases which warrant investigation and, in turn, those which can lead to administrative action or prosecution. The Inspector General's Office developed this procedure in coordination with the HEW Audit Agency.

As part of an increased effort to curb costly institutional fraud and abuse, HCFA is considering using this technique to examine abuse in nursing homes, through their links with pharmacies and commercial laboratories. Both Medicare and Medicaid reimburse considerably more money for institutional care than for services provided by physicians, pharmacies and laboratories.

Fraud and abuse in institutional care is extremely difficult to identify because of the complexities of the cost reports institutions are required to file for reimbursement. Some nursing home operators devise schemes to subvert the spirit, if not the letter of the law. For example, an executive of a nursing home chain wrote all the administrators in the chain suggesting they tell prospective patients to divest themselves of property in order to qualify as hardship cases under Medicaid. While the divestiture is not unlawful, suggesting it is unethical.

Many hospitals and nursing homes report incorrect costs due to honest mistakes or ignorance of the regulations governing reimbursements. Nevertheless, the Office of Program Integrity has found errors that resulted in millions of dollars of overpayments a year by the Government.

As an experiment, an accountant

began examining specific entries in 100 cost reports and related financial statements, SEC documents, and chain reports from the home offices of institutions. Working with resource people in the field, he uncovered six cases where the Government overpaid a total of $4 million. Arrangements are being made to recoup the funds. Expansion of this type of monitoring is being considered because there is evidence it would be a high-yield activity.

It should be emphasized that of the several hundreds of thousands of physicians, the facilities that provide health care and those who provide equipment, the vast majority of persons involved have a high degree of integrity. Unfortunately, as in many other fields, there are those in the health care industry who attempt to exploit and defraud the Medicare and Medicaid programs.

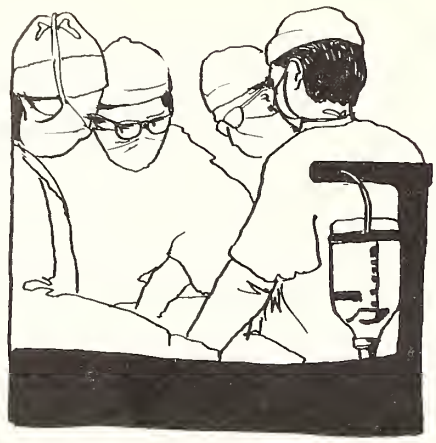
**Training personnel**

HCFA is currently helping States develop or improve their systems of detection and their procedures for taking action against violators. To improve the program, specialists in the central office and in the regional offices are planning a training program for Medicare and Medicaid investigators. This will cover:

- Techniques of investigating white collar crime.
- Cost reporting.
- In-depth information about the two programs.
- Bill processing and payment procedures of Blue Cross and Blue Shield and other contractors, as well as those of the States and their subdivisions.

Training programs are being packaged for new investigators who need a basic introduction to the program; for those who have been with the program for a few years, but need their skills sharpened; and for the program's supervisory corps.

While HCFA is still in a shakedown period, and the investigative forces of Medicare and Medicaid are being blended, we are, as Secretary Califano has pledged ". . . tackling strenuously the problems of fraud and abuse that so severely undermine our Government health programs." ■



## Study finds excessive rate of Medicaid surgery.

A congressional study concludes that surgery is performed on Medicaid patients twice as often as on the general public.

The study, which was conducted by the House Commerce Committee's Investigations Subcommittee, was based on an examination of 3.3 million operations paid for by Medicaid during 1976. The sample was drawn from 22 States, the District of Columbia and the Virgin Islands.

The study showed that for some types of surgery on Medicaid patients the frequency was more than twice as great as for the general population. However, inconsistencies in the data compiled by the States did not permit a precise rate to be established.

According to HCFA officials, surgery paid for under the Medicaid program should be both necessary and of high quality. The agency is reviewing the congressional study and its own statistics to determine the extent of unnecessary surgery on Medicaid patients and what actions may be appropriate.

However, a recent nationwide survey conducted for HCFA by the University of Michigan showed that rates of surgery at 2,000 hospitals were lower for Medicaid patients than for non-Medicaid patients in 1975.

HFCA is also undertaking a comparison of rates of surgery between Medicaid recipients and privately-insured patients to learn how much unnecessary surgery is being performed.

## Gov. Brown loses battle to regulate hospital rates.

An attempt to control rising hospital costs in California by Gov. Jerry Brown has suffered a setback. This occurred when a legislative committee failed to approve a proposal that would give a State commission the authority to regulate hospital costs.

Earlier, the State Health Facilities Commission had announced it intended to assume the role of a public utility agency, saying "The State has accepted the concept that health facilities cannot be controlled by marketplace, business as usual or supply and demand in the competitive sense." Since the 1973-74 legislative session, State law has defined health facilities as a public utility, but the law has not been implemented.

Governor Brown said that continued increases in hospital costs would probably make a ballot initiative for the proposal very attractive next year.


## Early rising doesn't earn rural physicians more.

A nationwide survey of physicians commissioned by HEW shows that rural physicians worked an average of 3.8 hours longer each week than urban physicians, and earned some $6,300 less per year. This was based on net earnings before taxes, without adjustment for cost of living differences between town and country.

There was some justice. Rural pediatricians worked 11 more hours per week than those in the city, and they earned more too — an added $1,300 yearly.

The typical physician put in 58 hours a week to earn $53,600. The highest average income for a specialty was earned by those in obstetrics/gynecology $64,600, while the general practitioner brought in the lowest, $44,800.

The survey which was made of 1975 income covered five specialties: general practice, pediatrics, internal medicine, general surgery and obstetrics/gynecology. It found that physicians with surgical specialties put in longer hours than those with medical specialties, and general surgeons worked longest of all.

A condensation of the survey, *Research and Statistics Note #13,* is available from the Editor, at HCFA/HEW Rm 5327, 330 C Street, S.W., Washington, D.C. 20201.

## States to lose millions in Medicaid funds.

Medicaid funds scheduled to be paid 22 States in October will be reduced by a total of $243 million because the States failed to properly conduct reviews of Medicaid patients in long-term care facilities. At press time Congress was considering legislation which would restore the funds. The reductions cover the second and third quarters of fiscal year 1977.

Annual reviews of these facilities are required by law and the same law sets mandatory penalties if reviews are not conducted.

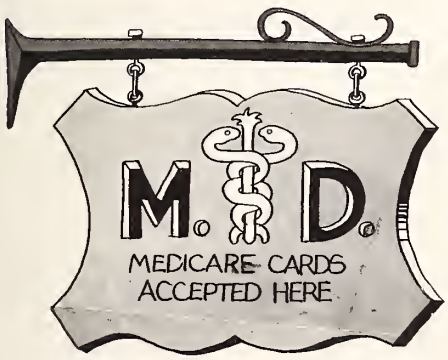
Some $134 million in payments for the second quarter would have been withheld from 19 States in July, but Congress postponed the action until October due to concern about the adverse impact the reduction would have on the state programs. In the third quarter, three states were added to the list and nine were removed. Alabama, Minnesota and Illinois were added and Alaska, Maryland, Michigan, Montana, Nebraska,

North Carolina, Ohio and Pennsylvania came back into adherence.

HEW Secretary Joseph A. Califano Jr. proposed legislation in June to sharply moderate the sanctions and to restore any funds withheld before new legislation is enacted. Legislation was subsequently introduced in the House.

States affected by the sanctions for the second and third quarters are: Alabama, $2.9 million; Alaska, $.3 million; California, $30.7 million; Colorado, $4.6 million; Illinois, $2.1 million; Iowa, $6.2 million; Kansas, $3.8 million; Maryland, $2.2 million; Massachusetts, $19 million; Michigan, $9.2 million; Minnesota, $5.3 million; Missouri, $2.9 million; Montana, $.4 million; Nebraska, $1.4 million; New Jersey, $9.4 million; New York, $107.6 million; North Carolina, $2.7 million; North Dakota, $.5 million; Ohio, $6.9 million; Pennsylvania, $13.6 million; Tennessee, $8.7 million; and Wisconsin, $.2 million.

A $1.2 million sanction against Indiana was withdrawn after the State submitted additional documentation that all reviews were performed.




## Society lists M.D.s who take assignment.

A list of local physicians who will accept assignment of Medicare benefits has been compiled for the public by the Multnomah County (Oregon) Medical Society. Accepting assignment means that the doctor will bill Medicare directly and will accept the fees determined to be reasonable by Medicare.

The list was compiled in response to a request by the Oregon Gray Panthers, an advocacy group of senior citizens. Telephone inquiries about the names of physicians accepting assignment are being answered by the medical society and the Gray Panthers.

The president of the society, Dr. Ernest Price, pointed out in a letter to members that many senior citizens find Medicare paperwork confusing. Assignment of benefits simplifies the payment process for the patient. To date, 81 physicians, mostly internists and general practitioners, have agreed to take assignment.

## Medicaid patients earn M.D.s slightly less.

Physicians who treat a greater than average percentage of Medicaid beneficiaries earn slightly less, while seeing more patients than those who treat relatively few Medicaid patients, according to a study by the American Medical Association.

Physicians with a higher proportion of Medicaid patients earned an average of $51,283 in 1974 and averaged 139.6 patient visits per week; physicians with fewer Medicaid patients had an average income of $53,142, but saw only 128 persons per week on average.

One reason for the difference appears to be fees: the Medicaid patients were charged $19.67 for an initial office visit on average in 1975, while the fee for a first office visit of other patients averaged $22.27. The same difference was observed in average fees for three other basic physicians services.

Those physicians seeing proportionately more Medicaid patients tend to be younger, slightly less experienced, more likely to be graduates of foreign medical schools and less likely to be board certificated, the study found.

Although Medicaid patients constitute 16.7 percent of all patients in the U.S., they make up less than 10 percent of the practice of more than half of all physicians. Only five percent of physicians report having 50 percent or more Medicaid patients.

# Letters to the Editor

To the Editor:

I found your article "Collections for Private Insurers" very interesting and it made me realize that we should get together with other States to exchange views on procedures for these recoveries. Most of the recovery ideas mentioned in your article are already being implemented by Oregon.

I thought you might like to know that, in addition to recovery from estates of deceased recipients and from personal injury claims mentioned in your article, our branch offices report to us transfers of property, both real and personal, without adequate consideration (which is illegal in Oregon) and report situations where recipients have been taken advantage of and their property literally taken from them (the rip-off). In this type of case, we either require consideration be paid or through a conservator set aside the transfer of property. Our data processing system, which is computer matched with the Department of Health, advises us of the death of a person who received assistance and owned real property or other assets of value.

It is time that the State of Oregon began communicating with other states relating to these programs. I would greatly appreciate your furnishing me with the names of the States having similar recovery programs.

Wm. Dobson, Manager
Estate Administration Unit
Department of Human Resources
Salem, Oregon


for you?

# Never Too Young to Learn.

## Study finds youngsters of six can be taught efficient use of health care services.

by Charles E. Lewis, MD
and Mary Ann Lewis, RN

Historically, efforts to curb health care costs have been directed at the providers of medical services and at the paper processing system, rather than at the patients themselves. However, the importance of consumers in holding down costs through their own behavior is enormous.

A variety of studies have demonstrated that a significant proportion of adults in the United States seek attention rather continuously for complaints that cannot be treated. In contrast, an equivalent proportion of the population delays seeking medical treatment despite signs of serious illness. (Men have a greater tendency to delay than women.) Studies of several groups indicated that from 10 to 15 percent of our population have no biological problems, but make over half of all visits for care. They are described by some as "the worried well." Their problems seem to have more to do with where they live and with whom, and the jobs they have or do not have. (More women than men seek care frequently.)

For those who receive appropriate treatment, less than half follow the recommendations of the physician. For example, the person with high blood pressure may have it appropriately diagnosed, receive a costly medical evaluation and an appropriate prescription, but the odds are that person will not take the medicine, or change his diet or his exercise habits. More than half the time human behavior — not the system — is the barrier to achieving good health.

Until quite recently, the origin of this unfortunate behavior was ignored. Six years ago, we began a research project to determine whether or not people could be helped to change their inappropriate use of health care services. We believed they could, based on the experience of a public health nurse* who had worked with inner-city children for two years during the late 1960s. The nurse's office was located next to an elementary school, and several children began dropping in to see her and talk about their health problems. She began seeing them on an appointment basis, and soon accumulated a group of patients.

It was her impression that when children were treated as adults (i.e., seen when they felt they had a problem of sufficient importance), they began to develop greater interest in their own health and act more responsibly. This raised the question: Would involving children actively in these decision-making processes shape some of their attitudes about health and make them more capable in dealing with problems?

To answer these questions, we set up a "laboratory" in an elementary school. Children were encouraged to initiate their own care and be involved in decisions about how their problems should be treated and managed. The laboratory was UCLA's University Elementary School, where the focus is on teaching decision-making in learning. This project began in 1972 and was funded by the National Center for Health Services Research.

In an effort to remove all barriers in seeking treatment, students are allowed to visit the nurse practitioner without asking a teacher's permission. They simply take a "care card" from one of the boxes located throughout the school, leave the top part of the card with the teacher and use the bottom part as a pass.

When the child arrives at the nurse's office, he is examined and given the facts. The nurse then asks the child for his opinions about treating his stuffy nose or bruised knee. The patient decides on the treatment that will be rendered, except when there is a risk to his health. There is a great deal of emphasis on positive reinforcement for good decisions, and discussion about options for taking care of the problem himself — if feasible — without visiting the nurse the next time it occurs. Thus, the child has a chance to practice aspects of decision-making related to health. We examined the children's beliefs about health care before the system was initiated, again six months later, and then two years after the system was in operation.

Our data suggests that by about the age of 6 or 7 children have acquired the same patterns of seeking health care services as adults. Twenty-three percent (mostly boys) never go to the

*Charles E. Lewis is a physician and professor of medicine at UCLA's Center for Health Sciences in Los Angeles. Mary Ann Lewis is a nurse practitioner and assistant professor of medicine and nursing at UCLA.*

*Mary Ann Lewis

nurse except for the hearing and vision screenings required by the school; and others go far too often.

About 10 to 15 percent of students without serious health problems make 50 to 60 percent of all visits to the nurse. These children come with a variety of complaints primarily related to the stresses they experience at home, in the classroom or elsewhere.

For example, a child may come in every morning at the same time with a headache. After careful questioning about the circumstances related to the onset of the headache, and after discussing it with the child, he usually begins to understand its cause. After a while, he may arrive at the nurse's office, saying, "I have a math headache." After such self diagnoses by the children, we noted they tended to modify their self-referral patterns.

The data from our study suggest that many of these children have fractured self-concepts rather than damaged bodies. In terms of their future health, this type of impairment may be even more devastating than a physical handicap. It seems that society tends to label some of us as "losers" very early in life. Seeking treatment for a sickness is one of the few legitimate ways to leave the race without competing and losing. Data on how the children's parents sought health care services suggest that family members serve as important models and that children learn to be consumers much earlier than they can be taught by conventional methods.

We are currently field testing the system in a public school district in California and, while the results of this study are not complete, we do know that the system can survive outside an experimental setting. The data also reveal the same patterns observed at the UCLA elementary school.

Thus far we have observed 500 students and have been able to track almost 200 students for four years. Based on this experience, we have been enormously impressed with the competency of children in making decisions about the kinds of problems they face.

Equally impressive has been the strength of the beliefs held by adults who feel that only *they* can make such choices for children. We feel that educating children to make decisions about their health care can be a powerful force in moving toward more appropriate use of health services. The resulting benefit of this is a population which is healthier and a health care bill which is lower. As long as we look to others to supply that which can come only from within, it appears the inefficiency of our current health care system will continue to be passed on from one generation to another. ■

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# FREE!

**For all state and local agencies and volunteer organizations. Eye-catching, full-color posters to publicize the Early and Periodic Screening, Diagnosis and Treatment Program.**

Place it in churches, self-service laundries, welfare offices, unemployment offices, day care centers, store fronts, low-income housing developments,supermarkets, food stamp distribution centers, and other places parents are likely to see them.

The poster copy reads:

The way to keep from having big health problems is to catch them while they're still small ones. If your children are eligible for Medicaid, we've got a program that will find and treat their health problems, if they have any, before they get too big. Why not check with your local welfare office and ask about the EPSDT program?

For your supply, write: Editor,
Room 5327 MES Building,
HEW
Washington, D.C. 20201


Poster comes in two sizes. Wall poster is 20″ x 23″. Standup poster is 11″ x 14″. Blank space at the bottom of the poster is for the address and telephone number for local information.

# Publications and Films

*Please address all inquiries and requests for publications and films to the addresses in the listings. Items for review should be sent to Darlene Young in care of this magazine.*

## Publications

**Health Care Delivery in the United States.** Steven Jonas, M.D. Springer Publishing Company, 200 Park Avenue South, New York, N.Y. 10003. $21.00.

This book is designed primarily as a text for introductory courses in health care delivery offered in medical schools, schools of public health, nursing schools, etc., but can also be used in non-health-oriented academic programs. Various elements of the delivery system and their interactions are examined. Articles by Dr. Jonas and his coauthors include: nursing, ambulatory care, hospitals, financing for health care, government in the health care delivery service, and national health insurance.

**EPSDT — Does It Spell Health Care For Poor Children?** Children's Defense Fund, 1520 New Hampshire Avenue, N.W., Washington, D.C. 20036. $4.00; Mailing cost 50 cents.

This study attempts to answer six basic questions about HEW's Early and Periodic Screening, Diagnosis and Treatment program for medicaid-eligible needy children:

- Was the program administered and enforced in such a way to assure children the benefits to which EPSDT entitled them?
- To what extent was EPSDT reaching children who needed its services?
- Were children's health problems being identified by screening?
- Were the necessary diagnoses and treatments being provided?
- How was the developmental assessment part of the program working and was it finding and helping children with developmental needs?
- Was EPSDT linking children to sources of continuing health care?

The report offers various viewpoints on the national program based on an examination of representative EPSDT projects in five states: New Jersey, South Carolina, Michigan, Mississippi, and New York.

**Childhood Illness.** Jack G. Shiller, M.D. Stein and Day Publishers, Scarborough House, Briarcliff Manor, N.Y. 10510. $2.45 paperback.

Aimed at parents, this book deals exclusively with the sick child, from infancy to adolescence. Chapters are arranged by symptom group for easy reference, and include: upper respiratory infection, bellyache, allergies, rashes, problems of the newborn, etc.

Separate sections deal with immunization, over-the-counter drugs and special problems. Also there is a glossary of additional conditions and other terms.

**Industry Wage Survey: Nursing Homes and Related Facilities, May 1976.** Bulletin #1964. Copies available from Dept. of Labor, Bureau of Labor Statistics, Wash, DC 20212, or any of its regional offices. Also available from Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

The results of a Bureau of Labor Statistics survey of wages and supplementary benefits in nursing homes and related facilities in 21 major metropolitan areas are summarized.

**Industry Wage Survey: Hospitals.** Bulletin #1949. Copies available from Dept. of Labor, Bureau of Labor Statistics, Washington, DC 20212, or its regional offices. Also available from Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

A survey of wages and supplementary benefits of hospital employees is summarized. It was conducted in 19 major metropolitan areas in August 1975 and in 4 areas in January 1976.

Private, State, and local government hospitals were included. A description of the pay systems in hospitals operated by VA, Public Health Service, and the Navy is presented in Appendix A.

**Directory of Social Health Agencies of New York City, 1977-78.** William J. Smith. Columbia University Press, 136 South Broadway, Irvington-on-Hudson, New York, New York 10533. $20.

The Directory provides concise information about public and nonprofit social and health agencies serving New York City.

Agencies are listed in two ways. Each is classified according to the service and function it performs. In addition, the agency index provides an alphabetical listing.

A separate section lists selected information and referral services in the United States and Canada and there is also a subject guide.

## Films

**Hope Today** and **The Young Adults.** 16mm color, RHR Filmedia, Inc., 1212 6th Avenue, New York, N.Y. 10036.

Both these films, jointly sponsored by HEW and the Dept. of Commerce, concern preventative health care for children, with emphasis on low income individuals. The films are available from the distributor on a short-term, free loan basis.

**Hope Today** is a 12-minute dramatization of a health crisis in a poor family, in which help is provided by a program of preventive health for children authorized under Medicaid. General audience.

**The Young Adults** presents a six-minute "rap session" among high schoolers on the subject of their health problems and needs. Audience: teenagers and parents. ■


Rocky Mountain Spotted Fever $729.99
Gall Stones $439.99
Tuberculosis $2499.99
Pneumonia $1399.99
Broken arm $149.99
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Slipped disc $499.99
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Second degree burns $2100.00

# Pinpointing the Costs of Hospital Services.

by Virginia Douglas, Assistant Editor

*For want of a nail the shoe was lost, for want of a shoe the horse was lost, for want of a horse the rider was lost, for want of a rider the battle was lost, for want of a battle the kingdom was lost — and all for the want of a horseshoe nail.*

— Benjamin Franklin
*Poor Richard's Almanac* (1758)

The ability to precisely measure the cost of treating each type of patient may be just as crucial in the battle to contain hospital costs as was the nail to the kingdom.

Until this is accomplished, no one can tell if a hospital's schedule of charges is reasonable. Nor can hospitals begin to be compared for efficiency.

Some of the advantages of pinpointing costs for each type of patient are:

- Hospitals would be able to zero in on inefficient practices and work to bring these costs down.
- Competition among hospitals would be encouraged, lowering the price of health care generally.
- A more equitable system of reimbursing hospitals could be effected.
- The cost of treating various types of cases at each hospital could be compared as well as the method of treatment — such as the type and amount of lab tests and the length of stay.
- Hospitals would tend to concentrate in areas where they are cost effective and leave areas of lesser efficiency to others.

According to preliminary results of a pilot study at 21 hospitals, it appears that a workable method of measuring dollar output for each type of patient is approaching reality. Work on this problem began more than five years ago at Yale University and in 1975 HEW funded a study to develop categories into which every patient would fit according to type of illness so that the average length of stay and a total cost for each category could be established. The ultimate objective was to develop a more equitable basis for paying hospitals.

To do this, three years of patient histories at the Yale-New Haven Hospital were studied. The hospital's patients were first divided into general diagnostic categories. Patients in each category were then subdivided into groups according to the dollars and length of stay necessary to treat them, while keeping those of similar diagnoses together.

Some 80,000 patients were categorized according to primary and secondary diagnoses, surgeries and age of each patient using a computer system that permitted rapid analysis of complex medical information. The resulting medically and statistically related groups of patients are called diagnostic related groups. For example, group No. 45 is for patients with urinary problems (see accompanying diagram).

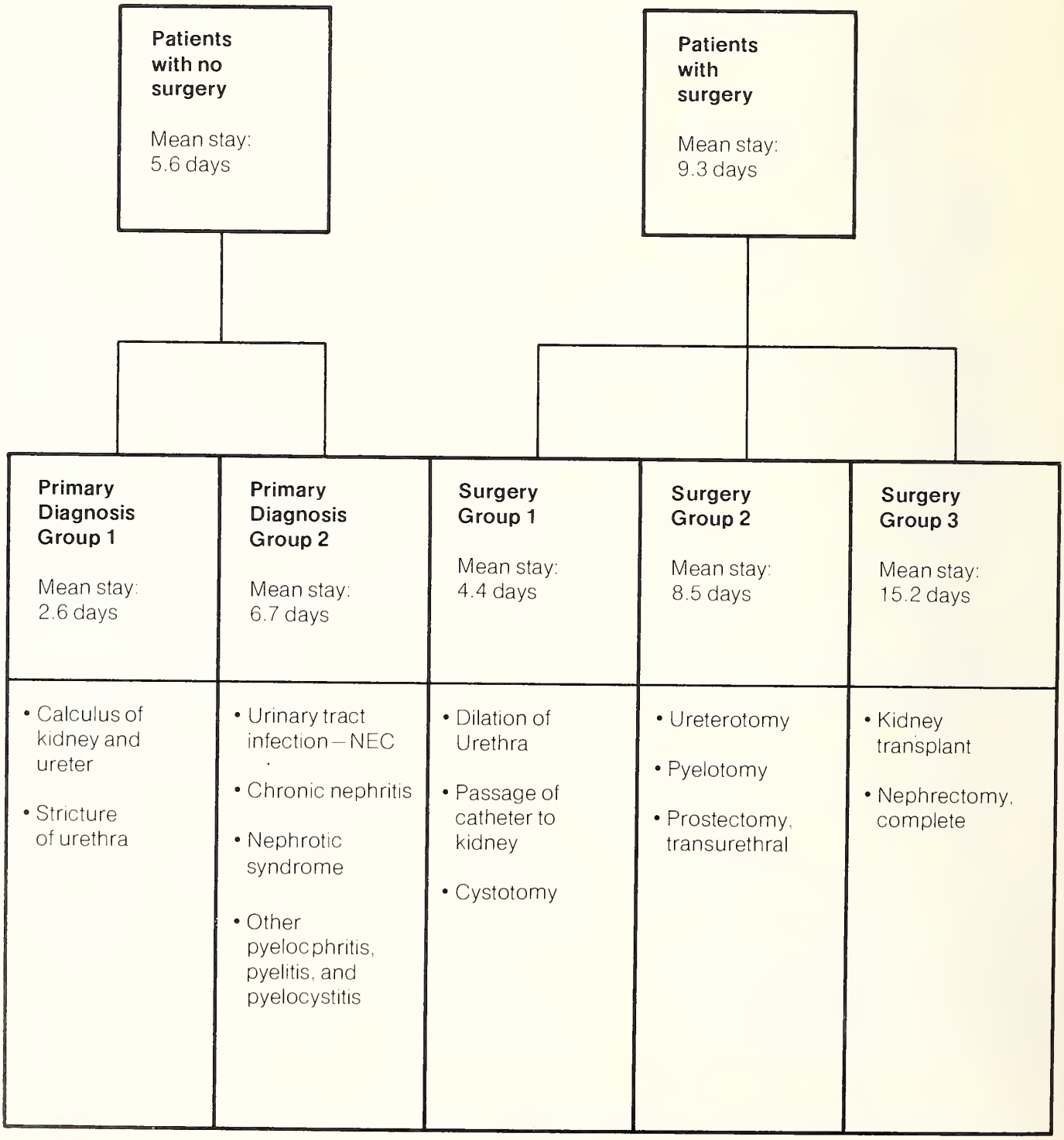
Next, an average cost for each category of treatment was determined by analyzing costs for the 80,000 patients. Various methods were used to arrive at these costs. For ancillary services (anesthesiology, pharmacy, laboratory, etc), patient bills were examined to determine the relative use of these resources by various diagnostic related groups. A study was made of nursing costs to determine the intensity of care required by patients in each group. For instance, a cancer patient might require two hours of nursing care a day, while a patient with a broken leg might need only one half hour. Fixed costs, such as administration, utilities, and plant maintenance, were allocated as indirect costs.

As expected, there was a range of costs for each treatment category, depending upon the general condition of the patient and other variables. But the range was narrow enough so that it was statistically valid to arrive at an average cost of treatment for each category.

In 1976, HEW funded a two-year project to test the Yale University method on a broader scale.

## Grouping Patients with Urinary Diseases According to Length of Stay

Mean Hospital Stay: 7.23 days



The first objective was to establish the validity of these groups in other hospitals and then to measure the amount of resources consumed by each of the State's diagnostic-related groups.

Starting in 1976, all hospitals in the State were required to submit medical abstracts for each patient to the Department of Health. From a six months' data base of more than a half million cases, 383 diagnostic-related groups were verified for use in New Jersey's 118 hospitals.

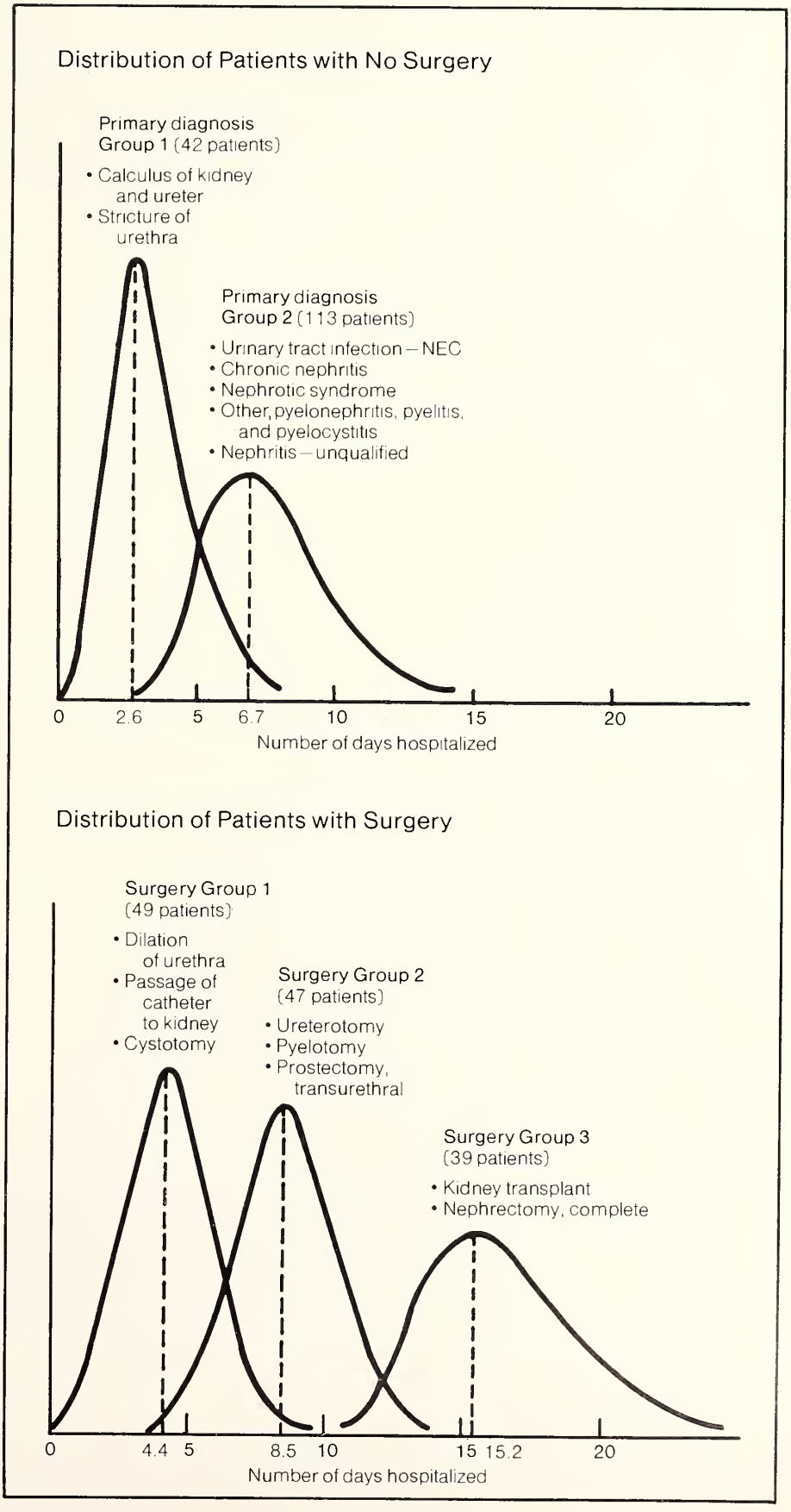
**Pinpointing Costs**

To determine costs for each group of patients in New Jersey, patient bills and statistical data for 21 hospitals were analyzed. Costs were broken out for 24 cost centers — four relating to nursing, four to general services, and sixteen to ancillary services. For ancillary services, costs were arrived at as follows: if one percent of all laboratory fees were charged to the group with urinary problems during a given year, one percent of the total operating cost of the laboratory for the year would be assigned to that group. General services, such as housekeeping, linen, laundry and medical records, were allocated proportionally, based on an analysis of sample cases. A special study is being done to determine the cost of various diets plus the dietitians' consulting time, broken down by diagnostic group.

A complicating factor in the process was that variations in billing procedures make it difficult to allocate costs and develop uniform rate structures. For example, in newborn billing, practices vary widely. Some hospitals place all charges for the new baby on the mother's bill while others start a separate bill for the newcomer when he arrives. Attempts to resolve such variations are underway.

**Studying nursing care**

Differing intensities of nursing care can cause wide cost variations. A three-part study to construct and validate measures of relative intensity of care by nursing skill level for each diagnostic-related group was undertaken as part of the project. The three segments are: a patient classification system/acuity instrument; an analysis



of nursing performance; and a nursing diagnosis study. This hybrid approach, testing three complementary methods of measuring nursing intensity, is unprecedented because each method serves as a cross-check against the others. It also allows measurement of nursing quality.

In the first study, conducted at three hospitals, five types of general nursing activities were identified and measured: assessment, planning and execution of an individual program of care for a patient; dispensing health information; giving emotional support and counseling; administering medication and other special care; and helping with the patient's physical functioning — hygiene, comfort, exercise, nutrition, etc. A questionnaire is being designed to match both actual and ideal nursing care to the patients' conditions to measure the intensity of care needed.

In the second study, the nursing performance analysis is being done in conjunction with the Mangement Engineering and Cost Control Services (MECCS) program of the American Hospital Association. Nurses at two hospitals are reporting routine tasks by skill level (RN, LPN, etc.). Using average times previously established by MECCS for these nursing tasks, researchers then match the information to patient diagnostic-related groups. This approach uses time-motion techniques to determine intensity of services.

The most innovative of the three, the nursing diagnosis study, measures both the nursing process and its effects on the patient. Twenty-eight nursing diagnoses of patients' social, emotional and physical concerns have been developed and quantified. Among these are anxiety/fear level, body image and sleep/rest activity. The nurses report the services they perform in each category. The object is to determine how nursing procedures affect the outcome of each patient's illness and length of stay.

The three measures developed will be tested in various kinds of hospitals (inner city, suburban, teaching, etc.), using different types of nursing models (team, case, functional or primary care) and nursing units (general medicine/surgery, intensive care, coronary care, etc.). Using the best results of all three studies, the researchers can determine the allocation of nursing costs by skill level, intensity of care, and patient diagnosis. This data will be used in setting 1979 hospital rates.

A group of nursing consultants, selected with the help of the New Jersey State Nurses' Association, is participating in the study. Among the consultants are nurse practitioners, administrators and researchers.

The method of reporting nursing costs is already changing in New Jersey. Formerly, each hospital reported general nursing service costs. Now four nursing cost centers are identified: registered nurses, licensed practical nurses, nursing attendants, and unit clerks. This breakdown permits a more precise measurement of costs.

### Monitoring efficiency

With costs pinpointed and each hospital's case load analyzed by category, a hospital can more easily determine where inefficiences exist and work to optimize its operations. For example, if a hospital administrator finds that pre-operative laboratory work for certain cancer patients takes 48 hours to complete, he may decide to cut this to 24 hours by bringing in more laboratory staff. This would effect savings in nursing, ancillary, and general services as well.

An efficiency index has been developed for length of hospitalization so both the hospital administrators and the Department of Health can spot inefficiencies. If patients in one treatment category are found to be hospitalized longer than the average, the administrator would examine his hospital's procedures to find the reason and make necessary changes.

Of course, the length of stay is expected to vary to some degree with the characteristics of the individual hospital, such as the extent of its diagnostic equipment. In a small percentage of cases, extremely long stays or particularly intensive services are observed when the case is compared to the average for its group. A reimbursement method for such cases is under development. For example, each case may undergo a medical review by the local Professional Standards Review Organization, which is charged with reviewing services provided by inpatient facilities. If the use of extra resources is justified, an increased reimbursement would be approved.

### Reimbursement next

Currently, the rate at which reimbursements are made to hospitals by Blue Cross and Medicaid is based on reasonable costs that a hospital incurs in the treatment of patients. The New Jersey Department of Health reviews hospital costs and sets rates on a per diem basis for hospitals across the State.

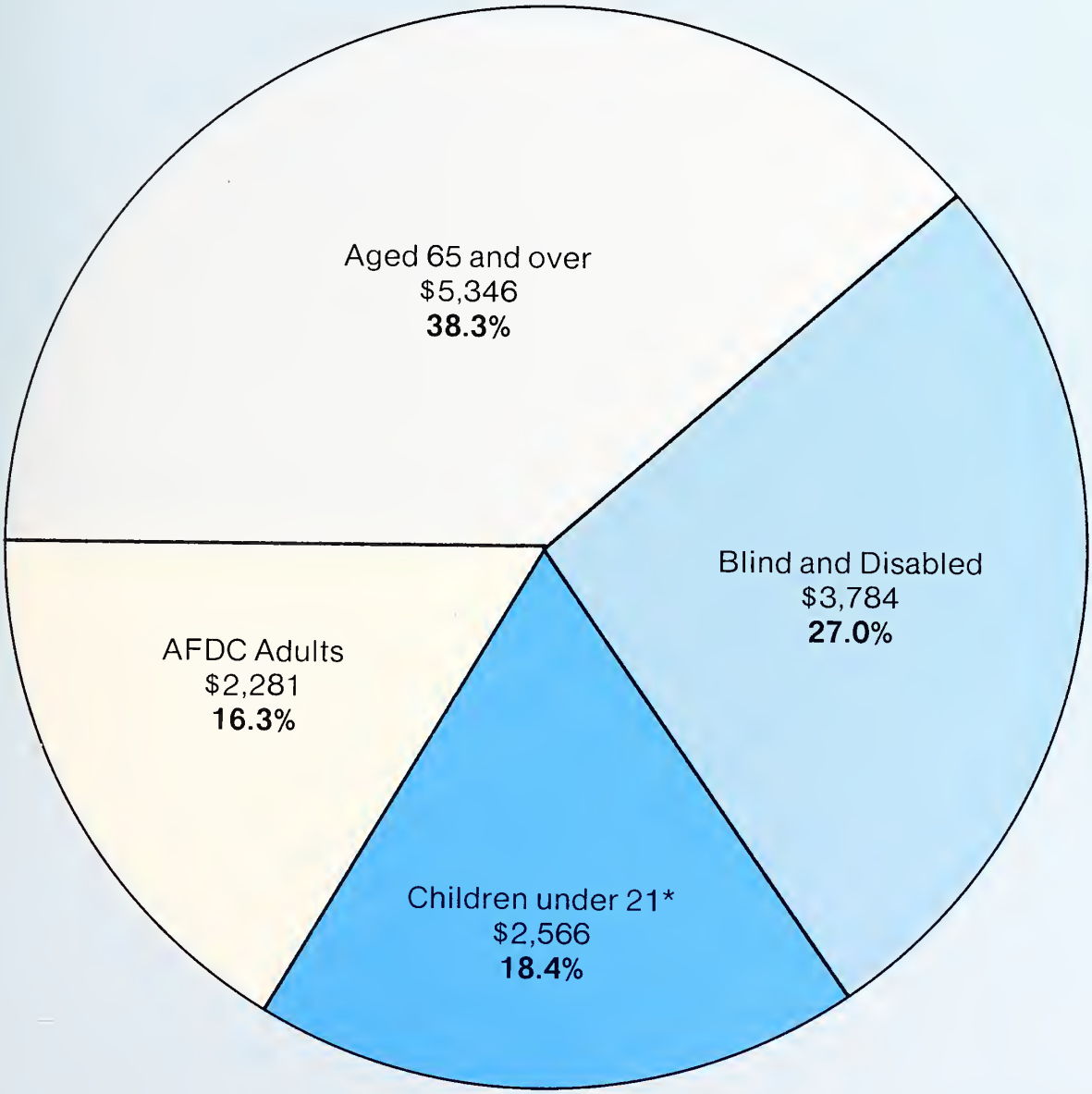
But now that the specific cost to care for each diagnostic-related group can be determined for these 21 hospitals, a uniform schedule of rates per case is easy to establish. If a hospital's costs exceed the rate, it may have to absorb at least a portion of the excess; but if the hospital holds costs below the fixed rate, it may be able to keep at least some of the savings. This creates the incentive to contain costs that has been lacking. The rate-setting system, which is expected to be extended to all 118 hospitals in the State, will allow more equitable reimbursement from Medicare, Medicaid, Blue Cross, and others.

The final phase of the program will require changes in State legislation to regulate the rates hospitals can charge Medicaid, Blue Cross, private insurers and individual patients. A waiver will be sought from the Federal Government to include Medicare patients under the case-mix system.

Although the new system is still being developed, it is already having an effect. Some hospitals are using the cost of treatment categories in appealing rate decisions by the Department of Health. For example, the Morristown Hospital claims that it should be able to include a larger amount for pharmacy services in setting its basic rates because it treats an unusually large percentage of cancer patients, who require a higher volume of expensive drugs. ■

# Medical Assistance Payments by Type of Recipient for Fiscal Year 1976

**(Dollars in Millions)**




Source: National Center for Social Statistics
*Includes children in AFDC families and other dependent children under 21.

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